Saskatchewan
Health

# Towards a Comprehensive and Integrated Ambulance Service for Saskatchewan

## Report of the Ambulance Review Committee

March, 1983

March, 1983

The Honourable Graham Taylor
Minister of Health

I have the pleasure to submit to you the report of the Ambulance Review Committee entitled "Towards A Comprehensive and Integrated Ambulance Service for Saskatchewan"

The report reflects many of the ideas and suggestions presented to the Committee by individuals and organizations. The report points to new directions the Committee feels will improve ambulance services within the Province. The Committee wishes to express appreciation to the individuals, associations, and groups who provided written and verbal presentations.

During the review the Committee came to realize that a strong need exists for an integrated and coordinated ambulance service within the context of a comprehensive emergency health system. The Committee feels that this approach to ambulance services provides the framework to ensure short term improvements and long term directions for continued development.

I wish to express my sincere appreciation to the Committee members and to all those who worked so diligently on the preparation of this report.

Respectfully submitted on behalf of the Ambulance Review Committee.

Larry Birkbeck.

L. Birkbeck
Chairman
M.L.A. Moosomin

TABLE OF CONTENTS

PAGE

COMMITTEE MEMBERS..... (i)
ACKNOWLEDGEMENTS..... 1
INTRODUCTION..... 1
PURPOSE OF AMBULANCE REVIEW..... 2
METHOD OF OPERATION..... 2
HISTORICAL PERSPECTIVE..... 3

FINDINGS..... 5
1. PROVINCIAL ORGANIZATIONS..... 5
2. ROAD AMBULANCE SERVICES..... 6
    2.1 Local Organization..... 6
    2.2 Service Utilization..... 7
    2.3 Personnel and Training..... 9
    2.4 Communications..... 11
    2.5 Vehicle and Equipment..... 13
    2.6 Funding..... 14
3. AIR AMBULANCE..... 18
    3.1 Existing Service..... 18
    3.2 Potential Use of Helicopters..... 20
4. PUBLIC AWARENESS..... 22

NEW DIRECTIONS - TOWARDS A COMPREHENSIVE
AND INTEGRATED AMBULANCE SERVICE
PRINCIPLES..... 23

1. PROVINCIAL ORGANIZATION..... 24
2. LEGISLATION AND REGULATIONS..... 24
3. ROAD AMBULANCE SERVICES..... 25
    3.1 Organization of Local Ambulance Services..... 25
    3.2 Personnel and Training..... 26

PAGE

3.3 Communications..... 28
3.4 Vehicle and Equipment..... 30
3.5 Funding..... 31
4. AIR AMBULANCE SERVICES..... 32
5. PUBLIC EDUCATION..... 34

SUMMARY OF NEW DIRECTIONS ..... 35

APPENDIX
List of Consultations

## MEMBERS

Larry Birkbeck
MLA Moosomin
Legislative Secretary
- Chairman, Ambulance Review Committee

Richard Fontanie
Senior Analyst
Bureau of Management Improvement
Saskatchewan Finance
- Principal Secretary

Walter Antonio
Director
Planning and Research Branch
Saskatchewan Rural Affairs

Donald Philippon
Director
Policy Research and Management Services
Saskatchewan Health

Keith Schneider
Assistant Deputy Minister
Saskatchewan Urban Affairs

John Wright
Senior Analyst
Budget Bureau
Saskatchewan Finance

## ACKNOWLEDGEMENTS

The Committee wishes to express its sincere appreciation to all individuals and groups who made written and oral presentations to the Committee. The views, concerns and recommendations provided were of valuable assistance in the preparation of the report. All formal presentations are on file for future reference.

The Committee also wishes to express its special appreciation to Donna Osatiuk, (former Director Emergency Health Services); Jim Simmons, Saskatchewan Urban Affairs; Neil Yeates and Joanne Havelock, Saskatchewan Health; and the clerical personnel of the Bureau of Management Improvement, Saskatchewan Finance.

## INTRODUCTION

The Committee recognizes a committed and dedicated people in the Ambulance industry representing a mix of private, community and volunteer service providers.

At the very early stages of the review the Committee became impressed with the complexity of the issues and concerns about the ambulance services in the Province. The Committee also learned this was further complicated by the lack of adequate background information on which to base an indepth analysis of the various situations.

The Committee nevertheless, acknowledges the need for a comprehensive and integrated approach to ambulance services throughout the Province. The approach recommended by the Committee for the improvement of ambulance services provides for:

- a recognition of ambulance services as an extension of emergency health services;
- the integration of ambulance services with other life support systems;
- a flexible structure to meet immediate needs and develop long term directions;
- a strategy for progressive development of emergency services over the next several years; and
- a consultative mechanism to ensure appropriate public input.

## PURPOSE OF AMBULANCE REVIEW

On September 14, 1982, the Honourable Graham Taylor, Minister of Health, announced the establishment of a committee to undertake an internal review of ambulance services. The main issues the Committee was to focus on were the organization, level of service, and funding. It was also to "deal with other areas which have direct implications for road ambulance, such as air ambulance and staff training standards."

Through a process of government department reviews and public consultations, the Ambulance Review Committee was to consider:

- the appropriate view of ambulance services;
- the division of responsibility of ambulance services;
- the integration of ambulance services with other related life support services;
- the type and level of ambulance services that should be available;
- the structure and organization of ambulance services;
- communication network for ambulance services;
- training and standards for ambulance attendants.
- the standards, and acquisition of vehicles and equipment; and
- the financing aspects of ambulance services.

## METHOD OF OPERATION

On September 16, 1982, the Ambulance Review Committee held its first meeting to establish the methodology of the review and to consider the terms of reference.

The subsequent meetings dealt with reviewing current programs with those responsible for the provincial services.

On October 1, 1982, the Committee requested submissions from individuals, groups and associations through public advertisement in all Saskatchewan daily and weekly newspapers. During the months of November and December the Committee received 69 submissions and met with 26 agencies and associations.

On October 15, 1982, a detailed questionnaire was distributed to all road ambulance operators throughout the Province. The purpose of the questionnaire was to provide current information to

the Committee. Seventy-one percent of the operators responded to the questionnaire.

The Chairman of the Committee visited various operators representing a cross-section of the types of ambulance services available within the Province.

Other jurisdictions in United States and Canada were contacted for a review of their Emergency Medical System with particular reference to ambulance services and its possible application to Saskatchewan.

## AMBULANCE SERVICES IN SASKATCHEWAN
## HISTORICAL PERSPECTIVE

### Road Ambulance Services

Saskatchewan Health has had licensing regulations for road ambulance since 1946. The initial requirements covered equipment and vehicle specification only. The regulations were upgraded in 1958 requiring that one attendant per call hold a standard St. John's First Aid certificate. In June 1980, new ambulance regulations were gazetted addressing vehicle equipment, personnel and training requirements.

Prior to the introduction of the Municipal Road Ambulance Program (MRAP), the provincial government's role in the provision of ambulance services was limited to the establishment of ambulance standards and inspection and licencing functions.

In 1978, at the urging of the ambulance operators faced with rising costs, increased user fees, and the threat of industry failure, a program was established to provide indirect provincial funding. The result was a strengthened regulatory role for Health and funding on a per capita basis through Municipal Affairs.

Municipalities joined together to form ambulance districts in order to provide joint ambulance services. These districts appointed boards to arrange for and oversee the provision of ambulance service in the municipalities. Provincial funding was provided to the municipalities through conditional grants under the Revenue Sharing Program. Municipalities inturn transferred the funds to the boards.

Currently, under the MRAP program, there are 100 active ambulance districts which have 95 licensed services available; 55 have contracts with 36 private ambulance operators; 29 with hospitals, and 5 with volunteer organizations. Eleven boards operate their own service.

In 1979, a Northern Road Ambulance Program modelled after MRAP was initiated through the Department of Northern Saskatchewan. The major difference between the two programs includes a grant formula which takes into account the higher operating costs associated with the northern environment. Currently there are 3 northern road ambulance districts.

In 1978, through the joint participation of the Saskatchewan Road Ambulance Association and the Saskatchewan Medical Association, and with support from Canada Manpower Industrial Training Program, a province-wide training effort was launched to up-grade the qualifications of the road ambulance attendants.

In 1980, at the request of the Saskatchewan Medical Association and the Saskatchewan Road Ambulance Association, the department of Continuing Education established the Emergency Medical Technicians (EMT - Level 1) program at the Wascana Institute of Applied Arts and Sciences in Regina. In 1981, a refresher program was initiated. The training program is guided by an advisory committee comprised of representatives of the ambulance attendants, operators, district boards, medical profession, other related groups and government departments.

Once an individual has EMT qualifications and 25 hours of actual emergency experience, a certificate is provided by the Saskatchewan Medical Association recognizing the individual as an Emergency Medical Assistant (Level 1).

## Air Ambulance Services

Since 1946, a provincially administered air ambulance system has served the function of rapidly transporting patients with serious medical conditions from remote communities to hospitals. With the development of an improved highway system, an upgraded hospital system, and an expanded road ambulance service, utilization of the air ambulance program stabilized and then began to drop off in the 1960's.

In the early years the air ambulance service was based in Regina and Saskatoon. The Regina base was discontinued as the

level of service declined. Presently the air ambulance service consists of a dedicated Navajo fixed wing aircraft and back up services are provided through the Executive Air Fleet and other commerical aircraft.

In addition to the provincially administered air ambulance service, a Medical Evacuation Program (Medivac) was initiated in 1975. This program enables physicians and nurses in the north to directly charter aircraft under emergency situations.

## FINDINGS

Over the past ten years ambulance services in Saskatchewan have witnessed many improvements, including:

- higher standards for vehicles and equipment
- improved two-way communication systems
- substantially increased number of dedicated vehicles
- updated regulations and increased regular ambulance inspections
- higher qualified ambulance attendants and drivers
- increased funding at the provincial level.

However, through presentations and extensive discussions with those concerned about the continued improvement of ambulance services, the Committee became aware of a number of difficulties.

The following sections outline the findings of the Ambulance Review Committee.

### 1. PROVINCIAL ORGANIZATION

1.1 The current ambulance service operates under five different pieces of legislation which several different government departments are responsible for:

- standard setting,maintenance and monitoring are the responsibility of Health;
- financing is the responsiblity of Urban Affairs, Rural Affairs and Northern Saskatchewan;
- training is the responsibility of Continuing Education; and
- administration is shared among Health, Urban Affairs, Rural Affairs, Continuing Education, Revenue, Supply and Services and Northern Saskatchewan.

The government's human resources dedicated to ambulance services and training are limited to 11 person years in five different departments.

1.2 Fragmentation of programming, split jurisdiction, and lack of human resources to support ambulance services inhibit long term planning and stability at the provincial and local level.

These factors contributed to the view among ambulance operators that the provincial government viewed ambulance service not as an integral part of the health care system but as a "transportation service".

1.3 An overwhelming consensus emerged from the presentations that all aspects of the ambulance program be merged into one administrative authority under the responsibility of Health.

1.4 The Committee was impressed with the number of organizations and associations interested in providing information and recommendations. Many submissions suggested that the difficulties associated with the ambulance program may have been minimized or dealt with outrightly if a mechanism had been in place to provide more consultation and program review between the provincial government and those interested in the development and operation of ambulance services throughout the Province.

## 2. ROAD AMBULANCE SERVICES

### 2.1 Local Organization

2.1.1 The development of ambulance districts provided the opportunity to organize ambulance services within defined boundaries. However, only boundaries of 21 ambulance districts resulted in being coterminous with those of hospital districts.

2.1.2 Boards were given the primary responsibility for the provision and the control of quality of service within their district. However, only limited direction,

support and encouragement from the Province was forthcoming. Some Boards are managing their affairs successfully, while others appear to do little more than transfer funds to ambulance operators. As well there is a lack of health care expertise on some boards.

2.1.3 The district boards are often caught between the municipalities and the operator because provincial funding is provided directly to local governments. On occasion the Committee heard examples of delays in payment of grants from municipalities to district boards causing short term financial hardship for the operators.

## 2.2 Service Utilization

2.2.1 The following is a summary of ambulance service utilization as provided by the survey of October 1982 and extrapolated to Saskatchewan's total population.

2.2.2 The survey respondents reported a total of 43,650 calls, and 3,136,874 kilometres. When extrapolated to the rest of the population, it is estimated that there were 49,500 calls involving 3,833,260 kilometres in the province in 1982.

2.2.3 The age distribution of calls indicates that utilization is highest among the very young (less than 2) and the very old (65 +). Nonetheless, the 2-64 year age group accounts for 63% of all calls.

CALLS ACCORDING TO AGE

| Age | # Calls | % | Population | Calls/1,000 Population |
|---|---|---|---|---|
| less than 2 | 3,811 | 7.7 | 32,505 | 117.2 |
| 2-64 | 31,136 | 62.9 | 841,518 | 37.0 |
| 65 + | 14,553 | 29.4 | 116,723 | 124.7 |
| TOTAL | 49,500 | 100.0 | 990,746 | 50.0 |

NOTES:

(i) The total number of calls has been extrapolated from the survey data and represents the entire province of Saskatchewan. Actual age data were reported for 39,089 calls.

(ii) Calls per 1,000 population have been calculated using SHSP Covered Population for 1981. The number of 1-2 year-olds in the province has been estimated to be one-quarter of the 1-4 year age group.

2.2.4 Emergency calls accounted for less than one-fifth (18.3%) of all calls. Nurse escorts were used for 3,223 calls (approximately 7% of all calls).

TYPE OF CALL

| Patient Initiated | # Calls | % |
|---|---|---|
| No Patient | 2,458 | 6.8 |
| Routine | 10,534 | 29.2 |
| Prompt | 9,135 | 25.3 |
| Emergency | 5,180 | 14.4 |
| Subtotal | 27,307 | 75.7 |
| **Hospital Initiated** | | |
| No Patient | 122 | 0.3 |
| Routine | 5,397 | 15.0 |
| Prompt | 1,848 | 5.1 |
| Emergency | 1,420 | 3.9 |
| Subtotal | 8,787 | 24.3 |
| GRAND TOTAL | 36,094 | 100.0 |

## 2.3 Personnel and Training

2.3.1 Regulations currently require ambulance operators in cities to have one Emergency Medical Technician (EMT) on each call. In non-city areas there is to be on staff at least one EMT trained attendant or physician or registered nurse. The driver of the ambulance is to have a class 4 drivers licence and a completed St. John's Ambulance first aid course.

2.3.2 The EMT (Level 1) Program provided through Wascana Institute consists of 131 hours of instruction. One permanent staff member coordinates the content of all courses. The program is offered on a decentralized basis throughout the Province.

2.3.3 It is estimated that by the end of 1982-83 fiscal year 425 individuals will have enrolled in the EMT program. It is estimated that there are 280 EMT's now employed in Saskatchewan ambulance services. Rural ambulance services tend to be staffed by part-time volunteers who often have full time jobs and, therefore, find it difficult to attend EMT courses.

2.3.4 Regulations require EMT's to successfully complete a refresher course approved by the Minister of Health every 24 months. In the event of failure, the EMT is required to enrol in a second refresher course within 6 months. If the EMT is again unsuccessful the entire basic course must be taken to regain certification. Refresher courses consisting of 21 hours are offered in Regina and Saskatoon.

2.3.5 It is estimated that 140 EMT's will have completed a refresher course at the end of the 1982-83 fiscal year.

2.3.6 Currently, there are no consistent Canadian training levels for EMT's. The Joint Ad Hoc Committee of the Canadian Medical Association for the Accreditation of Ambulance Training Programs is proposing a three level system for national standards and the provision for certification and reciprocity across Canada.

2.3.7 It was pointed out to the Committee that an essential factor in the development of emergency medical services in certain rural communities is the utilization of volunteers. It is estimated that there are 600 volunteers providing support services to ambulance operations throughout the Province. There are 5 operations which are totally run by volunteers.

2.3.8 Volunteer ambulance services can meet local needs, encourage cooperation at the community level and provide a credible emergency response team for rural areas.

2.3.9 The Committee heard conflicting statements regarding qualifications of attendants. Some submissions focused on the need for higher qualifications while others pointed to the need for greater flexibility and reduced standards. Concerns raised to the Committee included:

- the lack of career advancement for ambulance personnel;
- no advanced training programs offered in Saskatchewan;
- the shortage of EMT trained personnel in non-urban areas;

- the unrealistic requirement of an EMT on staff in sparsely populated ambulance districts;
- the acknowledgement of all those providing care in emergency situations as needing special skills and knowledge;
- a need for adequate training and continued up-grading of ambulance personnel;
- a need to offset the personal costs borne by ambulance personnel in up-grading their skills;
- a need for modules and distance training to meet specific training requirements;

2.3.10 There was strong support for the utilization of volunteers pointing to the need to maintain a flexible approach in the development of ambulance services. It was pointed out to the Committee that volunteers should be more fully recognized by the provincial government, and that on-going developmental support be provided to them.

## 2.4 Communications - Emergency Services

2.4.1 No uniform communication system exists. No ministerial direction has been provided on this matter. Although ambulance regulations state that all ambulances shall be equipped with a two-way radio of a type, power and frequency approved by the Minister of Health. However, a provincial radio frequency (158.76 KHZ) was recommended for use.

2.4.2 The data from the survey to ambulance operators indicated that fifty-six of the respondents (82%) stated that they used a VHF radio, while 3 (4%) used a radio-phone and 8 (12%) used a VHF and radio-phone. Seventy-eight percent of the sample employ the provincial radio frequency (158.76 KHZ).

Fifty-eight (58%) of the companies reported that a hospital in their district had a receiving station. The location of the ambulance dispatch centre was as follows: hospital - 42 (62%); ambulance headquarters - 21 (31%); private home - 3 (4%); and other - 2 (3%). In 13 districts there were more than one receiving station.

2.4.3 Saskatchewan Hospital Service Plan (SHSP) provides funding for the installation of base stations in hospitals. It is estimated that more than 50% of Saskatchewan hospitals are now equipped with receiving units.

2.4.4 A key to the effective use of emergency services is rapid entry into the emergency system. Unlike some communities in British Columbia, Alberta and Manitoba, Saskatchewan does not have a common emergency telephone number which gives easy access to emergency assistance.

2.4.5 The Committee heard numerous presentations about the lack of uniformity in the ambulance service communication system:

- ambulance operators and hospital receiving wards have different radio codes;
- existing VHF radio equipment only extends to 25 miles leaving operators who travel distances greater than 25 miles without communication with their base or with hospitals;
- there is limited local integrated communication systems and no regional or central communication system;
- there is no conformity of dispatch;

Rapid access to ambulance services may also be hampered by the fact that Saskatchewan Telecommunications is centralizing their telephone operator services. This may mean that telephone operators may not know which ambulance service at the local level to contact in the event of an emergency.

2.4.6 Submissions emphasized the importance of effective communication systems to:

- transmit information from one health care provider to another or from one facility to another;
- improve the preparedness of hospital emergency personnel;
- provide medical supervision to ambulance attendants;
- altert support teams such as police, fire and others when situations warrant it; and

- improve response time in order to reduce the effects of trauma and save lives.

## 2.5 Vehicle and Equipment Standards

2.5.1 Over half (55%) of 138 ambulances reported in the survey of October 1982 were purchased within the last four years.

MODEL YEAR OF AMBULANCES

| 66-71 | 72-77 | 78 | 79 | 80 | 81 | 82-83 |
|---|---|---|---|---|---|---|
| 3 | 51 | 8 | 26 | 19 | 16 | 15 |

2.5.2 The majority of ambulances in the survey (73%) were van conversions. The estimated life of a new vehicle varied from one to ten years depending on the size of the operation. In the larger services, a vehicle was shifted to a second, third or fourth vehicle as it got older.

TYPE OF VEHICLE

| | # Vehicles |
|---|---|
| Modular | 10 |
| Van Conversion | 100 |
| Raised Roof Van | 11 |
| Suburban Conversion | 7 |
| Other | 10 |
| TOTAL | 138 |

2.5.3 The Committee heard little concern expressed about the existing ambulance vehicle standards. Concerns centred on the need to keep abreast of technological changes, to have flexibility in allowing operations to up-grade vehicles, and to regulate equipment changes commensurate with training.

2.5.4 The Committee noted that there are no permanent staff assigned for the purpose of vehicle and equipment inspection. The Department of Health has only one temporarily assigned person for this purpose.

2.5.5 There are no approved national standards for vehicle and equipment.

2.6 Funding

2.6.1 A critical variable relating to the problems associated with ambulance service is funding for the industry. The Committee learned that there are several sources of revenue and expenditure for ambulance services which can be categorized as either service revenue or grants.

Service Revenue:

Service Revenue is generated from three sources:

User-fees: Payable by the patient or the party financially responsible for the patient. It is comprised of a basic call rate and kilometer charge. The decision to set call rates and kilometer charges rests with the district boards. The call rate ranges from a low of $35 to a high of $65. Kilometer charges range from $.06 per kilometer to $.55 per kilometer.

Insurance Companies: Outside of SGI which provides insurance for automobile accident victims, two other insurance schemes are available for partial ambulance coverage, Medical Services Insurance (MSI) and Group Medical Services (GMS). These latter insurance agencies currently contribute $1 million to ambulance services or an average of $50 per insured call. Currently, GMS and MSI pay $40 for an urban call and $35 plus 22¢ per kilometer for a rural call with a maximum of $100 per call and $300 per year. It is estimated that 68% of ambulance users have either GMS or MSI coverage.

Government Agencies: There are several federal and provincial government agencies which cover the costs of user fees set by the district boards. A separate arrangement exists between the Saskatchewan Road Ambulance Association and the Federal Department of Indian Affairs and Northern Development to pay for ambulance fees for Registered Indians living on reserves. The following table summarizes the estimated service revenue for 1981-82 and 1982-83:

ESTIMATE OF SERVICE REVENUE

| | 1981-82 | 1982-1983 |
|---|---|---|
| User fees | 800,222 | 880,244 |
| Provincial Government Agencies [1] | 1,284,110 | 1,469,521 |
| Federal Government Agencies [2] | 1,384,000 | 1,465,400 |
| Insurance [3] | 827,135 | 909,849 |
| Other | 9,878 | 11,202 |
| Total Service Revenue | 4,305,345 | 4,736,216 |

1. Includes revenue from Social Services, Saskatchewan Government Insurance, Attorney Generals and Saskatchewan Hospital Services Plan, Workers Compensation Board.
2. Includes Revenue from Department of Indian and Northern Affairs, and the Department of Veterans Affairs;
3. Includes revenue from GMS and MSI.

Grants:

The second major source of revenue for the road ambulance services is grants from the provincial and municipal governments.

Provincial Government. Through the Provincial Municipal Road Ambulance Program (MRAP) grants are provided to municipalities on a per capita basis.

Adjustments are made to the per capita grants on a sliding scale to accommodate population density. Grants are paid to participating rural and urban municipalities for forwarding to their respective ambulance districts.

MRAP funding has increased from $1.3 million in 1978-79 to $3.3 million in 1982-83. An extra subsidy of $500,000 outside of MRAP was provided to ambulance operators in 1982-83 making the total 1982-83 provincial grants $3.8 million. The distribution of 1982-83 Provincial grants to municipalities for ambulance services ranged from a low of $4,265 to a high of $416,446.

Through the Northern Road Ambulance Program a further $77,722 was provided for ambulance services in 1982-83.

Municipal Government. The official position of the municipal organizations of Saskatchewan Urban Municipalities Association (SUMA) and Saskatchewan Association of Rural Municipalities (SARM) is that ambulance services are a health service and as such are the responsibility of the provincial government. For this reason SUMA and SARM take the position that local governments should not finance any part of the ambulance industry from local tax dollars. However, the Committee has learned that presently there are at least 20 ambulance districts which have received municipal contributions ranging from $866 to $130,047.

Other. Ambulance operations also generate a portion of their revenue through donations from individuals and community volunteer associations. A summary of grant revenue follows:

ESTIMATE OF GRANT REVENUE

| | 1981-1982 | 1982-1983 |
|---|---|---|
| Provincial Grants [1] | 2,720,730 | 3,728,130 |
| Municipal Grants | 165,163 | 427,000 |
| Other (donations) | 207,535 | 228,288 |
| Total Grant Revenue | 3,093,428 | 4,383,418 |

1. Includes Northern Road Ambulance Program

2.6.3 It is significant to note that by adding all estimated 1982-83 expenditures the Province will be providing $5,197,651 for ambulance services. This represents 56.9% of all estimated road ambulance service expenditures.

2.6.4 The Committee heard many concerns relative to the funding arrangements for ambulance services including:

- The per capita grant system fosters inequity among the various districts as it presumes that all factors within a district are equal, and that the only variable is the population;
- the per capita grant is based neither on actual costs of an efficient ambulance operation nor on the level of service required by local conditions and local administrative arrangements;
- the current provincial grant payment system is not based on a common fiscal year and no uniform accounting principles and reporting systems are in place;
- there was a general consensus that there be a user-fee for ambulance services but concern was expressed about the varying levels and differences of user fees among the districts;
- because of the distance from rural communities to specialized treatment in urban centres, rural residents must pay significantly higher rates than urban dwellers. If rural residents are transferred from the local hospital to a major

urban hospital, the patient is billed for the call plus the kilometers travelled. On the other hand if a patient is transferred from one hospital to another within the city for the same specialized service there is no charge to the patient. The Committee heard examples of rural residents receiving bills of $250 for hospital transfers from smaller centres to larger cities. fural residents viewed such charges as grossly inequitable;

- revenue is insufficient to cover pay compensation for operators and ambulance attendants who work long and irregular hours;
- funding for the Northern Road Ambulance Program did not keep pace with the Municipal Road Ambulance Program.

## 3. AIR AMBULANCE SERVICES

The Committee reviewed both the existing air ambulance service and the potential utilization of helicopters.

### 3.1 Existing Service

3.1.1 The existing air ambulance service based in Saskatoon consists of one dedicated fixed-wing aircraft (a Navajo), two pilots and two nurses. Back-up services are provided by the provincial government's executive air fleet which consists of two Cheyennes and one Navajo. Also, arrangements are made with commercial carriers for both additional fixed-wing and helicopter aircraft as required. Under the majority of circumstances, however, the dedicated aircraft can handle the service demand.

3.1.2 The pattern of utilization has changed considerably since the introduction of air ambulance service in the 1940's. Up until 1960 there was a gradual increase in utlization, followed by a decline throughout the next decade. Since then there has been a levelling off of services. In 1981-82, there was a total of 446 flights involving 494 patients. The total number of flights consisted of 409 within the Province and 37 outside of the Province.

3.1.3 In most cases patients are in a stabilized condition and are being transferred from one medical facility to another. Most of the patients are taken to University Hospital in Saskatoon. Considering a full year's activity, the average length of a trip is 1-1/4 hours each way.

3.1.4 Nearly 60% of the flights are north of Saskatoon and this was part of the reason for basing the service in that city.

3.1.5 The financing of air ambulance service involves both a user-fee and provincial government subsidization. For in-province flights, patients are charged a flat fee of $140 (except for Treaty Indians in which case the federal government is charged the actual cost). Out-of-province flights are charged to the patient at the rate of $1.00 per mile each way except in cases where patients are being referred out of the Province for a service which is normally provided in the Province. In 1981-82, government expenditure on air ambulance service was $448,181 with a revenue of $190,981. The net cost to the Province was $257,200.

3.1.6 The utilization of air ambulance in the north has been affected by the introduction of the Medivac program. This program enables physicians and nurses in the north to charter aircraft. It is funded by the provincial government through the Northern Health Services Branch without any fee to the patient. In 1981-82 there were 251 Medivac trips.

3.1.7 The Committee heard several concerns relative to the air ambulance service in the Province:

- the Navajo aircraft is non-pressurized and, is limited to flying at low altitudes. This results in a rough ride which interferes with critical medical procedures being used to stabilize the patient;
- there continues to be a lack of some specialized equipment;
- presently communications between attending staff in the aircraft and medical personnel in hospitals is only possible by relaying messages through air traffic control. This system is inadequate and causes concern to both the attending nurses and to

the traffic controllers. With the introduction of more advanced life support equipment, better air to ground communication becomes increasingly important to ensure the required medical direction for procedures;

- when air ambulance staff are out, an answering service is used to receive calls. This can lead to problems in evaluating the extent of an emergency and in initiating appropriate action;
- there are substantial differences among physicians regarding the use of air ambulance services;
- the charging and mandating policies of the provincially administered air ambulance and the Medivac program are inconsistent. This may have an impact on the utilization of air ambulance in the north;
- the policy of charging the patient $1.00 per mile has been critized where it involves the transfer of patients from a Saskatchewan hospital to an out-of-province facility for specialized care not available in the Province. Arguments have been made that this type of service should be fully insured since the treatment is not available in the Province;
- time delays of the dedicated aircraft in reaching northern communities are too long and suggestions have been made to base a second dedicated aircraft in La Ronge;
- chartered aircraft are often not equipped to handle medical situations. They are utilized for freight and transport but not as a dedicated ambulance service; and
- northern airstrips improvement is required for night take off and landing. Without the ability for night flying, residents may be required to use more costly modes of transportation.

## 3.2 Potential Use of Helicopters

3.2.1 Significant advances have been made in the application of helicopters in emergency medical services. The helicopter emerged in civilian use in California in the early 1970's. Since that time, applications have spread and today there are 57 hospital centres in the United States with helicopter service. In Canada, the only regular helicopter service for emergency health

services is located in Ontario and is based in Toronto.

3.2.2 Experience from elsewhere suggests that the introduction of helicopter service must be done with many other supporting elements. Not only must there be a close integration with emergency medical services, but specialized equipment and appropriately trained staff are essential to the effective utilization of helicopters. Moreover, in most applications of helicopter services, it has been found necessary to secure a back-up helicopter.

3.2.3 The high cost of helicopter service continues to be the major obstacle to more widespread utilization. The basic helicopter unit itself starts at about $650,000 and ranges to over $3 million depending on the size and sophistication of the craft. Equipping the unit with emergency medical equipment adds another $50-$75,000. In addition, staff cost to provide a 24 hour service and maintaining the necessary back-up helicopter and repair packages have to be included. Recent American literature suggests that contracts for helicopter services generally involve payments of $25,000-$30,000 per month with an added charge for flight activity, in some cases up to $275 per flight hour.

3.2.4 Experience from elsewhere also suggests that helicopter applications are most effective in areas where there is a high density of population within a radius of 210 kilometres and where traffic congestion exists in the major urban centre.

3.2.5 The high cost of the helicopter itself and the associated support elements, such as equipment, staffing, maintenance and back-up services, render the introduction of this type of craft inappropriate at this time. Injection of resources of this magnitude can be more effectively utilized in other areas of emergency health services. However, this does not rule out the continuing consideration of helicopter services for Saskatchewan in the future.

## 4. PUBLIC AWARENESS

4.1 Saskatchewan is a large province with a relatively sparse and scattered population. Accordingly, there will be time delays between the occurrence of an emergency and the arrival of emergency assistance.

4.2 Several studies in the United States and Canada have shown that substantial number of lives can be saved and trauma minimized through prompt action by knowledgeable citizenry backed up by a rapid-response emergency medical system.

4.3 The Department of Continuing Education, through the Community College network and with the support of the Saskatchewan Heart Foundation, provides the opportunity for the public to learn cardio-pulmonary-resuscitation (CPR); as well other basic first aid courses are provided by such organizations as St. John's Ambulance and Red Cross.

4.4 Many of the presentations expressed the view that further first aid education for the public, beginning in the school system, would be an important step towards providing emergency care to injured persons and reducing the effects of serious trauma.

The presentations also suggested community emergency agencies such as police and fire as well as industrial safety personnel could further develop skills to deal with emergency health situations.

## NEW DIRECTIONS - TOWARDS A COMPREHENSIVE AND INTEGRATED AMBULANCE SERVICE

In considering proposals for improving Saskatchewan ambulance services, the Committee wishes to recommend practical resolutions to many of the immediate issues while at the same time setting the stage for future development. To this end the Committee endeavored to achieve a balanced approach to:

- fostering a comprehensive and integrated ambulance service within the context of an emergency health system;
- establishing a basic set of ambulance service standards while maintaining flexibility to accommodate new approaches to the provision of emergency health services; and
- reducing the inequities in the existing ambulance services while recognizing the differences between urban and rural settings.

## PRINCIPLES

The Ambulance Review Committee formulated "New Directions for Saskatchewan's Ambulance Service" on the following principles:

- that ambulance services be integrated with an Emergency Health System at the provincial and community level;
- that ambulance services at the provincial level be consolidated;
- that local autonomy in the planning and delivery of ambulance service be encouraged;
- that a mix of community, volunteer and private operated ambulance services be maintained;
- that there be flexibility in the development delivery and funding of ambulance services;
- that a basic level of service be established throughout the Province with the option to provide a higher level of service;
- that a closer link be developed between ambulance services and hospitals;
- that ambulance district boundaries and hospital district boundaries be rationalized over time; and
- that ambulance services be reasonably accessible and equitable in urban and rural areas.

## 1. NEW DIRECTIONS - PROVINCIAL ORGANIZATION

In order to recognize that ambulance services are an integral part of the health care system, reduce fragmentation of ambulance service programming, provide clear and consistent direction to the ambulance service industry, improve the capacity for integrated emergency health planning, and improve communication between the ambulance industry and the provincial government, the Committee recommends the following:

**1.1 The Province take steps to develop an Emergency Health System.**

**1.2 Ambulance services be viewed as a health care service within the context of emergency health.**

**1.3 Ambulance services become the responsibility of the Department of Health.**

**1.4 An administrative unit reporting at a senior level be established to:**
- **administer, fund, set standards, licence and monitor the road and air ambulance service;**
- **determine training requirements and the method for certification of ambulance attendants; and**
- **provide field staff to assist local ambulance district boards and operators.**

**1.5 A provincial advisory body representing the various groups involved in the provision of services be created to provide on-going communication concerning the direction and development of ambulance.**

## 2. NEW DIRECTIONS - LEGISLATION AND REGULATIONS

2.1 Currently ambulance services come under several different pieces of legislation. For this reason the Committee recommends that **the Minister of Health consider separate legislation for ambulance services.**

2.2 Any new legislation or regulations should consider the impact on existing services and provide for a period of transition. Any future regulations should accommodate the advances in ambulance services.

## 3. NEW DIRECTIONS - ROAD AMBULANCE SERVICES

### 3.1 Organization of Local Ambulance Services

3.1.1 To provide effective ambulance services, the Committee feels local autonomy is essential to respond to community needs. It is also important that the health care system be integrated and coordinated with other emergency health services and particularly with hospitals.

The Committee noted that several communities have begun to move in this direction by:

- dispatching ambulances from hospitals;
- locating ambulances at hospitals;
- utilizing hospital personnel as a resource for ambulance services; and
- aligning the ambulance district boards with hospital boards.

The Committee recognizes, however, that not all communities can achieve the same level of integration because of local and practical considerations.

3.1.2 To further the integration and coordination of health care and ambulance services the Committee recommends that: **ambulance district boundaries be rationalized with hospital district boundaries. In addition, where feasible, ambulance and hospital services be administered by one board.**

3.1.3 The Committee recognizes that the rationalization of ambulance districts and hospital boards will take time and recommends that **provincial resources be made available to assist in this process.**

3.1.4 In the longer term the Committee also sees the need to group ambulance service districts into regions.

The role of a regional service may include emergency health services at a more specialized level, incorporating back-up emergency ambulance services. The Committee recommends **that if regional configurations are determined that the boundaries be coterminous with other health regional boundaries.**

3.1.5 The Committee also urges communities to consider the importance of ambulance services within a total emergency response system linking them with fire and police departments and other community support systems.

3.2 Personnel and Training

3.2.1 The development of an effective emergency health system will require the utilization of a variety of personnel including physicians, nurses, emergency medical technicians and volunteers. Training opportunities in life support services will be essential to meet the varied needs of each of the groups.

3.2.2 As a basic level of qualifications the Committee endorses the current standards for ambulance personnel incorporated in the existing regulations under the Public Health Act:

- **that ambulance services operating in cities shall have on each call a qualified Emergency Medical Technician;**
- **that ambulance services operating outside of cities have at least one attendant on staff, who is a qualified Emergency Medical Technician or a physician or a registered nurse;**
- **that drivers of ambulances hold a class 4 licence and a first aid certificate issued by the St. John's Ambulance; and**
- **that ambulance attendants complete a refresher course every 24 months.**

3.2.3 To further enhance ambulance services the Committee recommends that:

- **drivers of ambulance vehicles take emergency driving courses and advanced training in life support;**

- **ambulance dispatchers have training in dealing with emergency situations; and**
- **volunteers and part time personnel have emergency care training available to them.**

This training could incorporate components of the existing EMT program to permit a career ladder for those who later want to obtain additional training. Such training could take the form of life saving and injury reducing techniques of approximately 80 hours. The course could also be delivered through the community college network. The Committee noted that such a course is available in Manitoba and may have application in Saskatchewan, particularly in the rural areas.

3.2.4 **Because of the distance from the nearest ambulance service in rural areas and smaller centres the Committee recommends the development of "first responder teams."**

Such teams located at the community level could be made up of people with health training and volunteers with training specifically designed for this purpose. These teams could be organized similar to volunteer fire departments and would be available to respond immediately to a local situation and apply basic first aid while awaiting the arrival of an ambulance.

3.2.5 The Committee further recommends that training courses be:

- **designed for a variety of groups and be provided at several levels;**
- **flexible to meet the different needs from the volunteer to the medical profession;**
- **provided at the local level through distance learning modules;**
- **provided on a progresive basis giving recognition to previous training and experience in emergency care; and**
- **sensitive to the local cultural and socio-economic circumstances of the area.**

3.2.6 With respect to EMT training the Committee recommends that:

- **the current EMT (Level 1) course be the basic EMT (Level 1) course for Saskatchewan but that consideration be given to meeting the Canadian Medical Association standards for EMT training;**
- **EMT courses continue to be made available through Wascana Institute on a decentralized basis but that further distance learning modules be explored so that both the professional and volunteer sector may take advantage of the course; and**
- **a committee similar to the existing Advisory Committee to Wascana Institute continue to be involved in the on-going training and that consideration be given to incorporating this Committee into the provincial advisory body previously recommended.**

3.2.7 It is important that ambulance attendents with limited opportunity practice their skills and have refresher courses available to them. The Committee suggests that there may be ways to accomplish this through:

- **simulation exercises at the local level;**
- **exchange programs among ambulance districts with higher incidents of emergency situations; and**
- **ambulance attendents situated in hospital emergency departments.**

3.2.8 Given the rapidly changing technology in emergency medical care it is important that training opportunities be made available for advanced life support systems. As a step in this direction the Committee recommends that **the training for EMT (Level II) be available for those districts wishing a higher level of service.**

The Committee further recommends that **the introduction of more advanced training in life support systems be given serious attention in conjunction with the longer term development of an emergency health system.**

## 3.3 Communications

3.3.1 An effective communication system is mandatory to provide rapid entry into the emergency network, and to

maintain contact with medical personnel and other emergency agencies.

3.3.2 The Committee recommends that **Saskatchewan's ambulance service move towards a uniform communication system with common codes and frequency.**

3.3.3 The Committee has noted that Saskatchewan Telecommunications has the technical capability to more effectively coordinate rapid access to an integrated emergency response system through a 911 telephone number in several cities. Such a system would signficantly improve the ambulance response time to more than one third of Saskatchewan's residents.

It would appear the application of a 911 response system is not practical throughout the Province in terms of cost, technical capacity and utilization. **However, the Committee suggests that larger centres which have the technical capability give serious consideration to implementing a 911 response system.**

The Committee explored alternate cost efficient systems which would achieve a higher level of integration and alleviate the problems associated with distant communications currently experienced by many operators. The Committee concluded that a VHF mobile unit combined with a mobile telephone system tied into hospital emergency departments has the most advantages at relatively efficient cost. This sytem combines the current VHF frequency for ambulances with mobile telephone and provides rapid access to virtually all health-care providers and other emergency agencies throughout the Province. Such a system would also aid in:

- alerting ambulance attendants of emergency situations;
- alerting hospitals as to the condition of the patient;
- maintaining contact with base stations;
- receiving support from other-care providers; and
- organizing back-up support as required.

The Committee recommends **that a VHF mobile unit combined with a mobile telephone system be placed in**

**all ambulance vehicles where feasible be tied into hospitals.**

The Committee also recommends that **where applicable the dispatch for ambulance services be located in hospitals.**

3.3.5 The Committee has noted that clearer direction in telephone directories could be given for ambulance services in smaller centres. Ambulance services are often located under the company and not located at the beginning of the directory. The Committee recommends that **all telephone numbers of ambulance services be clearly shown on the inside cover of telephone directories.**

Considering Saskatchewan Telecommunications move to centralize the functions of telephone operators the Committee recommends that **the feasibility of a zenith number for ambulance services be explored.**

3.4 Vehicles and Equipment

3.4.1 The Committee **endorses the existing vehicle and equipment regulations and recognizes the need to continue to up-grade regulations in response to emerging technological developments.**

In introducing changes to the existing standards the proposed administrative unit should be aware of the need to:

- **provide sufficient lead time to phase in technological changes;**
- **train ambulance attendants to use the equipment and technology.**

3.4.2 The Committee also recommends **the practice of inspection checks be continued to ensure that all vehicles and equipment meet standards under all expected conditions.**

3.4.3 The Committee **supports the concept of establishing national standards for ambulance vehicles** and urges the proposed provincial administration unit to work with its counterparts in other jurisdictions to this end.

3.5 Funding

3.5.1 The Committee realizes that there are several ways to finance ambulance services. These range from a total provincially funded service to a completely privately funded service. The Committee also realizes that costs associated with ambulance services can escalate at an extremely rapid rate according to the approach taken The Committee suggests that the approach to funding not only take into account today's economic realities but also be based on the following criteria:

- **a need to establish a province-wide basic level of ambulance services;**
- **a provision to advance that level over time as dictated by local requirements;**
- **a need to reduce the inequities and inflexibility found in the current funding arrangement;**
- **a need to further stabilize as well as improve the accountability of the ambulance industry; and**
- **a need to ensure local input over ambulance operations.**

3.5.2 The Committee recommends that a new approach to funding be adopted which has the following features:

- **changing the existing per capita grant formula to a more equitable grant system which would take into account annual call volumes, all revenue, approved expenditure categories, and year end adjustments to accommodate specific requirements;**
- **continuing the federal, provincial and private insurance agencies financial input into the ambulance system;**
- **funding a basic level of ambulance services through provincial grants, user fees and the above mentioned agencies;**
- **providing provincial grants directly to the ambulance district boards;**

- **establishing a ceiling on user-fees and allowing district boards to adjust the user-fee up to that ceiling; and**
- **encouraging local financial contributions to offset costs that go beyond the provincially approved basic level of service.**

3.5.3 If the Province intends to adopt a new approach to funding, the Committee recommends **a one year timeline to allow for the transition to take place.**

3.5.4 The Committee further recommends that there be:

- **a common accounting and regular reporting system for ambulance operators and boards;**
- **a common fiscal year based on the provincial fiscal year of April to March;**
- **annual audited financial statement of ambulance operators and boards;**
- **a province-wide information system established in conjunction with boards and operators; and**
- **consideration be given by ambulance district boards to provide a minimum three year contract to ambulance operators.**

## 4. NEW DIRECTIONS - AIR AMBULANCE SERVICES

4.1 In view of the size and population distribution of Saskatchewan, an air ambulance system will continue to be a vital element of the emergency health services in this Province. This will require ongoing development so that an effective air ambulance service becomes integrated within the total emergency health system.

4.2 To foster this development, the Committee recommends that:

- **the air ambulance service become an integral part of the proposed administrative unit;**
- **contractual arrangements for aircraft and associated staff continue with the Department of Revenue, Supply and Services; and**
- **the working relationship between the air ambulance and neonatal transport services be continued and strengthened with respect to sharing of staff and equipment.**

4.3 The Committee recognizes the need for a separate means of air services to transport patients in the north. However, the Committee recommends that the existing Medivac program and the air ambulance service be rationalized as follows:

- **a user fee be charged for all Medivac trips; and**
- **the air ambulance be contacted first in all cases involving the movement of patients out of the north to a southern hospital. This does not rule out the possibility of chartering aircraft if the air ambulance cannot provide appropriate service.**

4.4 The administrative unit should place initial emphasis on:

- **the clarification of the role and the development of common understanding among physicians;**
- **the possible placement of the air ambulance dispatch within a hospital emergency department; and**
- **the promotion of the most effective mix of road and air ambulance utilization.**

In the longer term, consideration be given to:

- **the location of a dedicated aircraft at La Ronge;**
- **the improvements of airstrip conditions in the north and the development of "life support modules" for easy insertion into chartered aircraft; and**
- **the rapidly changing technology with respect to both fixed and rotary wing aircraft and life support equipment for air services.**

4.5 The Committee further recommends that **consideration be given to upgrading the air ambulance service to include a pressurized aircraft with flight phone, more advanced life support equipment and more advanced training for the attending nurses.**

4.6 With respect to fees for air ambulance, the Committee recommends that:

- **the in-province fee level be adjusted to bring it into line with the ceiling which is established for the road ambulance service; and**

- **the in-province fee be applied in cases where Saskatchewan residents are referred outside the Province for essential emergency medical services not available in Saskatchewan.**

## 5. NEW DIRECTIONS - PUBLIC EDUCATION

A knowledgeable public able to act in emergency health situations has proven to save lives and reduce trauma. Currently there are available to the general public courses in first aid, CPR, and artificial resuscitation. The Committee wishes to recognize and commend the many individuals and organizations promoting first aid throughout the Province.

**The Committee recommends that a comprehensive program of public awareness be introduced to educate citizens in emergency health care.**

Such an initiative could include:

- **a promotional campaign using media, literature, education extension through the education system and service clubs;**
- **extending the availability of first responder courses for the general public;**
- **the provision of certificates of merit to those who make significant volunteer contributions to emergency health care in their community.**

## SUMMARY OF NEW DIRECTIONS

### 1. PROVINCIAL ORGANIZATION

- the Province take steps to develop an Emergency Health System;
- ambulance services be viewed as a health-care service, and become the responsibility of the Department of Health;
- an administrative unit be established to direct provincial responsibilities for ambulance service; and
- a provincial advisory body be established to provide on-going communication concerning the direction and development of ambulance services.

### 2. LEGISLATION

- the Minister of Health consider separate legislation for ambulance services.

### 3. ROAD AMBULANCE SERVICES

#### 3.1 Organization of Local Ambulance Services

- preserve local autonomy and support a mix of community, volunteer and private operators;
- coordinate ambulance services with the hospital system;
- rationalize ambulance district boundaries with hospital district boundaries, and where feasible have ambulance and hospital services administered by one board;
- provincial resources be made available to assist in the process of rationalizing boundaries and boards; and
- in the longer term regionalize emergency health care at a more specialized level with back-up ambulance services.

#### 3.2 Personnel and Training

- the current regulations form the basic level of qualification for ambulance personnel;
- further enhance ambulance services by providing drivers with emergency driving courses and advanced training in life support, dispatchers with training in dealing with emergency situations, and volunteers and part time personnel with emergency care training;

- courses be designed for a variety of groups giving recognition to previous training and experience in emergency care; be sensitive to local cultural and socio-economic circumstances and be provided at the local level through distance learning modules;
- the current EMT (Level 1) course be recognized as the basic course for EMT (Level 1) qualifications but consideration be given to meeting Canadian Medical Association standards for training;
- EMT courses continue to be decentralized through Wascana Institute of Applied Arts and Science but further distance learning modules be explored so that more people can take advantage of the courses;
- a committee similar to the existing Advisory Committee to Wascana Institute of Applied Arts and Science continue but consideration be given to incorporating this committee into the provincial advisory body recommended;
- develop "first responder teams" particularly in rural areas and smaller centres;
- training for EMT (Level II) be available for those ambulance districts wishing a higher level of service; and
- the introduction of more advanced training in life support systems be given serious attention in conjunction with longer term development of the emergency health system.

## 3.3 Communications

- Saskatchewan's ambulance service move towards a uniform communication system with common codes and frequency;
- larger centres that have the technical capability give serious consideration to implementing a 911 response system;
- VHF mobile units combined with a mobile telephone system be placed in all ambulance vehicles and where feasible tied into hospitals;
- where applicable the dispatch for ambulance services be located in hospitals;
- telephone numbers of ambulance services be clearly shown on the inside cover of telephone directories; and
- the feasibility of a zenith number for ambulance services be explored.

## 3.4 Vehicles and Equipment

- endorse the current vehicle and equipment regulations with recognition to upgrade the regulations in response to developments in emergency technology;

- provide sufficient lead time to phase in technological changes;
- train ambulance attendents to use the equipment and technology;
- continue inspection checks; and
- support the development of national standards for ambulance vehicles and equipment.

## 3.5 Funding

Criteria for funding:

- a need to establish a province-wide basic level of ambulance services;
- a provision to advance that level over time as dictated by local requirements;
- a need to reduce the inequities found in the current funding arrangement;
- a need to further stabilize as well as improve the accountability of the ambulance industry; and
- a need to ensure local input over ambulance operations.

Recommended approach to funding:

- change the existing per capita grant formula to a more equitable grant system which would take into account annual call volumes, all revenue, approved expenditure categories, and year end adjustments to accommodate specific requirements;
- continue the federal, provincial and private insurance agencies financial input into the ambulance system;
- fund a basic level of ambulance services through provincial grants, user-fees and the above mentioned agencies;
- provide provincial grants directly to the ambulance district boards;
- establish a ceiling on user-fees and allowing district boards to adjust the user-fee up to that ceiling;
- encourage local financial contributions to offset costs that go beyond the provincially approved basic level of service; and
provide one year time line to allow for transition of new funding approach.

Further recommendations:

- a common accounting and regular reporting system for ambulance operators and boards;
- a common fiscal year based on the provincial fiscal year of April to March;
- annual audit of financial statements of ambulance operators and boards;
- a province-wide information system established in conjunction with boards and operators; and
- consideration be given by ambulance district boards to provide a minimum three year contract to ambulance operators.

4. AIR AMBULANCE SERVICES

- air ambulance service become an integral part of the proposed administrative unit;
- contractual arrangements for aircraft and associated staff continue with the Department of Revenue, Supply and Services;
- working relationship between the air ambulance and neonatal transport services be continued and strengthened with respect to sharing of staff and equipment;
- air ambulance be contacted first in all cases involving the movement of patient out of the north to a southern hospital;
- charter aircraft be used if the air ambulance cannot provide appropriate service;
- consideration be given to upgrading the air ambulance service to include a pressurized aircraft with flight phone, more advanced life support equipment and more advanced training for the attending nurses;
- the in-province fee level be adjusted to bring it into line with the ceiling which is established for the road ambulance service;
- the in-province fee be applied in cases where Saskatchewan residents are referred outside the Province for essential medical services not available in Saskatchewan; and
- a user fee be charged for all Medivac trips;

The proposed administrative unit place initial emphasis on:

- the clarification of the role and the development of a common understanding among physicians;
- the possible placement of the air ambulance dispatch within a hospital emergency department; and
- the promotion of the most effective mix of road and air ambulance utilization.

In the longer term, consideration be given to:

- the location of a dedicated aircraft at La Ronge;
- the improvement of airstrip conditions in the north and the development of "life support modules" for easy insertion into chartered aircraft; and
- the rapidly changing technology with respect to both fixed and rotary wing aircraft and life support equipment for air services.

5. PUBLIC EDUCATION

- to improve the capacity of Saskatchewan citizens to respond to emergency health situations a comprehensive program of public awareness be introduced.

# APPENDICES

## APPENDIX - CONSULTATIONS

| | | |
|---|---|---|
| September 23 | D. Osatiuk | Dept. Health |
| | J. Simmons | Dept. Urban Affairs |
| September 30 | D. Osatiuk | Dept. Health |
| | J. Simmons | Dept. Urban Affairs |
| October 7 | D. Osatiuk | Dept. Health |
| | J. Simmons | Dept. Urban Affairs |
| | A. Herd | Dept. Continuing Ed. |
| October 14 | J. Munroe | HeliTronic Consulting Sask. |
| | B. Pultz | Pultz Aviation Research Ltd. |
| October 22 | C. Gray | Northern Health Services |
| | C. Supernault | Assist. Deputy Minister, Northern Saskatchewan |
| | G. Stinson | Director Municipal Services, Branch, D.N.S. |
| October 28 | J. Hessian | Tristar Industries Yarmouth, N.S. |

| | | |
|---|---|---|
| November 4 | J. Masson | Sask. Emergency |
| | B. Rosiac | Medical Technician/ Assistant Association |
| | M. Nadish | Saskatchewan Road |
| | D. Crook | Ambulance Association |
| | D. Hayter | |
| | D. Wagg | |
| November 17 | R. A. Wankling | Saskatchewan Urban |
| | H. Taylor | Municipalities Assoc. |
| | A. Shaefer | Supervisor, Sales Mobile Systems, Sask Tel |
| | K. G. Biholar | Supervisor, Mobile Radio Services, Sask Tel |
| November 18 | J. Marjerison | Saskatchewan Health Care Association |
| | H. Helmsing | |
| | B. Woulds | |
| | W. Pettit | |
| | G. Allsen | |
| | I. A. Powick | Aerospatiale Helicopter Corp. Delta, B.C. |
| | B. Pearson | Consumer Association Canada (Sask) |
| November 25 | D. L. Benson | Director Central Vehicle Agency |
| | F. E. Hanton | Manager Aviation, Central Vehicle Agency |

| | | |
|---|---|---|
| | Dr. L.M. Brand | Saskatchewan Medical Association |
| | Dr. R.L. Ailsby | |
| | Dr. A.D. Monday | |
| | Dr. N. Stimpson | |
| | Dr. E. Baergen | |
| | A. F. Cosgrave | |
| | D. Shauf | Southeastern Sask. Road Ambulance Association |
| December 1 | C. Phelps | Saskatchewan Assoc. of Rural Municipalities |
| | I. Thiessen | |
| | L. Wilkinson | |
| December 2 | J. Knox | Saskatchewan Registered Nurses Association |
| | H. Grimm | |
| | D. Rae | |
| | C. Weder | |
| | K. McDonald | Bell Helicopter (Textron) |
| | W. A. Samouce | |
| December 7 | Dr. W.B. Firor | Saskatchewan Heart Foundation |
| | Dr. L. Horlick | |
| | B. Hill | Imperial, Sask. |
| December 9 | P. Byl | Inland Aero, Consulting Services, La Ronge, Sask. |
| | G. Skomorowski | |
| | E. Oliver | |

| | | |
|---|---|---|
| | D. L. Benson | Central Vehicle |
| | F. E. Hampton | Agency |
| December 15 | R. Cole | Ambulance |
| | S. Wilson | Attendants Saskatoon |
| | M. Perry | |
| | S. Bush | |
| December 17 | Chief M. Isnana | Saskatchewan |
| | Chief S. Brass | Federation of Indians |